

# Medical Care Advisory Committee

*Minutes of September 15, 2016*

## Participants

### Committee Members Present

Andrew Riggle (Chair), Dr. William Cosgrove, Mark Brasher, Sara Carbajal-Salisbury (via phone), Debra Mair (via phone), Christine Evans, Danny Harris, Steven Mickelson, Mark Ward, Kevin Burt, Peter Zeigler (via phone), Nate Checketts, Doug Springmeyer, (via phone), Jenifer Lloyd, Jessie Mandle

### Committee Members Excused

Adam Cohen, Jackie Rendo

### Committee Members Absent

Jonathan George, Donna Singer

## Guests

Joyce Dulcourt-LCPD, Ed Dieringer-UAHC, Kris Fawson-USILC, Matt Hansen, Utah Association for Home Care (via phone).

## Welcome

Andrew Riggle called the meeting to order at 1:34 p.m. Andrew welcomed everyone and introduced two new MCAC members, Jessie Mandel and Christine Evans. Jessie Mandle represents advocate groups from Voices for Utah Children and Christine Evans, consumer Medicaid recipient representing families. Andrew also welcomed Jenifer Lloyd to the MCAC executive committee.

Andrew announced two open positions for membership representing the dental profession and consumers from the mental health community.

Andrew asked for attendance via phone.

## Approval of Minutes

**MOTION:** Jenifer Lloyd moved to approve the August 8, 2016 minutes. Dr. Cosgrove seconded the motion. All approved. None opposed.

## New Rulemaking

### Craig Devashrayee – New Rulemaking

Craig spoke on the rule **R414-1-5 Incorporations by Reference**. Subsection 26-18-3(2)(a) requires the Medicaid program to implement policy through administrative rules. This change, therefore, incorporates the most current Medicaid state plan and provider manuals by reference to July 1, 2016. This was filed July 13, 2016 and is effective September 15, 2016.

**R414-302-6 Residents of Institutions.** The purpose of this change is to provide Medicaid coverage to individuals who reside in certain halfway houses and are eligible for Federal Financial Participation (FFP). Filed today September 15, 2016, with a proposed effective date of November 7, 2016.

A question was asked what populations reside in halfway homes. Jeff Nelson spoke and reported halfway homes are community correctional centers (CCC). It was reported in Utah there are seven halfway homes with approximately 60+ individuals and its estimated 15 eligible individuals will be affected by this rule. The CCC's house individuals from the corrections population. Jeff further explained the new rule states if an individual is housed in a CCC and are able to leave in the course of the day (example: working) and return at night, they can be eligible. They were not eligible in the past. No other questions were asked.

### Jeff Nelson – Eligibility Update

Jeff presented a handout on the Medicaid totals. Jeff reported a slight decline in Medicaid enrollment with adult, pregnant women and children which has not changed from last month. Chart also showed a slight increase for people with disabilities and people over age 65, which was explained this will always be up and down. Jeff reported it's believed the ACA has run its course, and in the coming months it's expected to have moderate decline in the total enrollments. The PCN totals were not reported this month but will be reported next month. The title and year on the report will also be corrected for next month.

### Kevin Burt -School Lunch Demonstration Program

Kevin reported on the free school lunch program and the eligibility determination process. Kevin stated with an agreement in place they have worked with USOE, to provide information on individuals eligible for food stamps, which is then used to determine eligibility for the free school lunch program. Individuals eligible for food stamps are automatically eligible for free school lunch without having to provide any additional paper work.

Kevin announced that recently an application was submitted for a pilot program to expand the program to Medicaid children. These children would be eligible for either free or reduced lunch.. Utah was selected for the pilot and will be using Medicaid information to enroll children in the free and reduced lunch program as of September 1, 2016. DWS is in the final testing phase and will be ready to implement soon. It was noted one of the rules of this agreement is if a percentage of children (at that school) are eligible for free lunch the entire school is eligible.

Dr. Cosgrove asked how the program was funded. Jessie Mandle stated that the USDA, Food Nutrition Services (FNS) funds this. Danny Harris asked if the individuals/students were automatically enrolled. Kevin reported there is an educational component and the schools helps families enroll. He also stated the current process of collecting information from USOE is working well. Danny Harris asked if schools are able to use this data for other school fee waiver programs. Kevin stated an agreement would be needed to use this data. The data is very specific to free and reduced lunch. Nate stated it is a privacy issue and would need a different discussion for this to happen. It doesn't fit under the normal use of health information. Kevin stated food stamp data is usually a little easier to use because it's not health data. Jessie asked how this information is getting out to families. Kevin stated it is the school's responsibility to inform families because it is a school program. DWS and DOH aid them in simplifying the process.

### John Curless – Elimination of the “in the home” Requirement for DME

John presented a handout giving an update on the February 2, 2016 regulations on home health and DME supplies, reporting on three key elements.

Face-to-Face Encounter

- Encounter related to the “primary reason” the person requires home health
- HH/DME provider shall document face-to-face encounter from physician/practitioner
- Home Health – between 90 days before and 30 days after start of services
- Medical equipment - no more than 6 months prior to start of services

#### Medical Supplies/DME

- States can have a list of approved items
- States are prohibited from having “absolute exclusions” and must have a process to request items not on the list.
- “Suitable for use in the home” is replaced with “any setting in which normal life activities take place
- Home health can’t be limited to “homebound”

#### Managed Care

- Note required by Code of Federal Regulations (CFR) to follow changes
- Best practice
- Anticipate requiring ACOs to comply with these updates
- Consistent approach will result in less confusion regarding Medicaid clients

Compliance date is July 1, 2017 for Utah

Staff are still reviewing regulations to determine needed changes.

Dr. Cosgrove questioned examples of durable medical equipment. John read a definition for durable medical equipment. Dr. Cosgrove asked how quickly someone can get DME. John stated the provider should be contacted to get DME. They would contact the vendor to get it. Medicaid would be billed for it. They would need to meet the face-to-face encounter requirements.

Andrew asked what the face-to-face encounter consists of, and what documentation is needed. John referred to the handout for the definition and was unable to give specifics at this time. Andrew gave an example of seeing a provider, and the request for DME being brought up during the appointment. John said these are the types of situations that will be reviewed to determine how they should be handled.

Joyce Dulcourt-LCPD, asked what the process is for requesting DME that is not on the list. John stated there is already a process in place with committees to review these requests.

Danny stated his interpretation of “encounter” related to primary reason for DME. In response, Ed Dieringer- UAHC, commented what is happening in the Medicare Federal OIG rule. Ed reported on the concerns and mis-interpretations regarding the federal rule on face-to-face encounter and stated until there is real guidance and specifications there will be different interpretations, and he does not see this issue going away soon. Andrew asked Ed if he is hearing of these issues with Medicaid patients or just Medicare. Ed stated it is currently Medicare driven. We haven’t heard much for Medicaid because of the pre-authorization process.

Dr. Cosgrove commented on issues with pediatric patients who leave the hospital and need DME, and physicians who are not “in the loop” until later and they need a face-to-face encounter to qualify. John commented he believes it could be the original practitioner who did the encounter and determined the need for DME.

Andrews asked who the other “authorized physicians/practitioners” are. They are:

- Nurse practitioner or clinical nurse specialist
- Certified nurse mid-wife (limited)
- Physician assistant acting under a supervision of a physician.

Andrew asked is this going to require adjustments to program policy in terms of what Medicaid covers for DME, specifically wheelchairs. John said this is still in review.

Steven Mickelson commented regarding the procedural process as he related his concerns regarding patients with legitimate and reasonable needs, versus the less legitimate reasonable needs when individuals are asking for services.

### Nate Checketts – Director’s Report

Nate reported the adult expansion waiver is still pending. Nate reported that the federal comment period ends on September 17<sup>th</sup>. There has been one comment so far from AUCH. DOH is in continued contact with CMS every other week. DOH continues to request from them guidance, and really a decision, on whether they will allow the two new concepts (chronic homeless and justice involved) as a new 1115 waiver population. DOH has asked CMS on when they will move forward with this, but they haven’t committed to a date.

Nate next reported that even though the waiver has not been denied, during the last call with CMS there was discussion whether DOH would consider the HCBS State Plan Option 1915(i). Nate distributed a handout describing the program requirements of a 1915(i) waiver. DOH is still investigating whether this waiver would be an option to consider. Nate stated DOH has submitted some questions to CMS for clarification. Nate gave a summary regarding requirements:

- Level of care - Institutional level of care is not required.
- Application Process - State Plan amendment, must have multiple State Plan amendments if covering different target groups.
- Approval Duration - One-time approval or if using targeting option, renewals every 5 years
- Reporting - Annual reports
- Public Input - Regulations is silent
- Target Groups - May define and limit the target groups(s) services
- Limits on Number Served - Not allowed
- Waiting Lists - Not allowed
- FMAP - Standard
- Participant directed Services - Allowed
- Person centered Support Plan - Required
- Cost effectiveness – None

Dr. Cosgrove asked what a “person centered support plan” is. Nate explained.

Andrew asked about the requirement of targeting services to specific groups, and anyone who fits those criteria must be served, and how DOH would deal with the dollars allocated. He asked if there are concerns with this. Nate stated that piece of the 1915(i) matches with what we would do with the 1115, in terms of serving those meeting the criteria.

Dr. Cosgrove asked the difference between a waiver and a state plan amendment. A state plan is a contract with CMS detailing how Utah operates their programs, in our case the Medicaid and CHIP program. CMS has different approval processes to make adjustments. In the case of a 1915(i) waiver we would be revising the state plan. Waiver processes are more involved creating exceptions to the state plan and benefits outside the state plan. The 1115 waiver is reviewed separately at headquarters in Baltimore, MD. Nate stated there are different “vehicles” to get things approved.

Danny Harris asked if there has been any indication from CMS if they are going to “run out the clock” on a decision. Nate stated CMS responded there are approximately 15 -17 waivers ahead of UDOH and that they are reviewing those first. Danny asked if submitting a 1915(i) would change the timeline. Nate stated it could potentially change the timeline, as it could take some more work upfront.

Danny Harris asked if there was a concern of the cap regarding the mental health and substance abuse population who are eligible for General Assistance. Is this a concern of CMS? Nate stated they have not raised this as a concern yet. Jessie asked about any concerns on the parent piece. No concerns have come up, and if DOH requested the parent piece separate, this would be separate from the rest of the waiver. If CMS states parents are approved, and the waiver is denied, DOH would go back to the Legislature for a final decision. Nate also explained the budget neutrality piece of the 1115 waiver and how DOH has used that to fund PCN. He also explained that CMS is going to change the way they count savings after 5 years. It was asked how we control the numbers if we can't cap enrollment under the 1915(i). Nate explained that the bill was written broadly to cover the chronically homeless and told here's the money you have to do it. It was DOH's job to look across the populations and write definitions that were very limited to control who is covered and to stay within the range. Whether the population is covered under either waiver, it is believed it will be controlled by the definitions.

Question was asked if the population would be served by an ACO or by fee-for-service if done under 1915(i). Nate explained the bill states the recipients will be covered by ACO's, but there are still things that need to be worked out in this regard.

Jessie questioned if the waiver was not approved, will the Legislature protect the funds. Nate remarked there would likely be no protection if denied. Nate clarified at this time there has been no denial of the waiver, only speculated rumors.

Nate gave an update regarding the federal law requiring Medicaid provider re-credentialing every 5 years. If providers have not re-credentialled by September 24, 2016, they will be disenrolled. They will not get reimbursed for Medicaid services. At this time there are approximately 2,700 providers on hold, noting 400 are actively billing DOH for services. The 400 identified are on hold and DOH is working to get them re-credentialled. It was noted if they do not submit their re-credentials by the due date they will have to re-apply in DOH's new PRISM system and start over. Discussion on if there were any concerns if the providers did not re-apply. DOH has cleared most of the non-active providers as they have been identified as not billing for more than 4 years or had dropped off. Danny Harris asked if there will be a network adequacy issue with providers being disenrolled. Nate stated there are between 8,000-10,000 active providers billing DOH, so this is not an issue.

Tracy Altman, U of U Health Plans, spoke regarding the concerns on re-credentialing on behalf of the ACOs. She reported their provider relations teams have been reviewing the list and those not re-credentialled are being educated and reminded of what they need to do.

## Other Items

Andrew reported there were two new agenda topics received for October.

- Krissann to discuss access monitoring review plan with input.
- Discussion on concerns regarding Home Health Care and working more effectively with the ACOs.

Andrew summarized the agenda items suggested for future months. If there are topics for consideration please email to Jennifer Meyer-Smart at [jmeyersmart@utah.gov](mailto:jmeyersmart@utah.gov).

**MOTION:** Danny Harris moved to adjourn meeting. All were in favor. None opposed.

Adjourned meeting at 2:59 p.m.